Top 50 Error Reason Codes With Common Resolutions

(10-12-04)

On the following table you will find the top 50 Error Reason Codes with Common Resolutions for why claims deny at Virginia Medicaid. This list has been provided to assist you with resolving denied claims prior to calling the Helpline. Please print and post this list within your office for easy reference and use.

Error Code	Description	Common Resolutions
0003	Billing Provider ID Number Missing or not in Valid Format	**CMS-1500** -place the 9 digit billing Provider Number to the right of the PIN# in Locator #33 **UB-92**- place the 9 digit billing provider number in Locator #51 ***NOTE: <u>if you have a seven digit provider number place two leading zeros before the number.</u>**
0004	Enrollee ID Missing or Not in Valid Format	**CMS-1500**- verify the enrollee number for eligibility. Place the correct 12 digit enrollee number as it appears on the Medicaid Card in Locator #2 **UB 92**- verify the enrollee number for eligibility. Place the correct 12 digit enrollee number as it appears on the Medicaid Card in Locator #60
0015	Primary Carrier Payment Missing or Invalid	**CMS 1500**-if claim was submitted with a COB code of '3' (primary carrier billed and paid) in Locator 24J, the correct payment from the primary carrier must be in Locator 24K **UB-92**-if claim was submitted with a COB code of '83'(primary carrier billed and paid) in Locator 39-41 under 'code', the payment made by the primary carrier must be under 'amount'.
0022	Servicing Provider is Not Eligible to Bill this Payment Request Type	The servicing provider must be eligible within our system to bill certain claim types. Verify the correct claim type /provider specialty with the Provider Helpline.
0038	The Place of Treatment is Missing or Invalid	**CMS 1500** –Locator 24B must have the correct Place of Service code. Please resubmit claim with the correct Place of Service code. The complete list of Place of Service codes can be found on CMS' website - www.cms.hhs.gov
0039	Qualified Medicare Beneficiary Only Enrollee. Medicaid coverage limited to deductible and coinsurance.	Qualified Medicare Beneficiary (QMB) Only clients are eligible only for payment of Medicare premiums, deductibles, and coinsurance. If a QMB Only claim is denied by Medicare then there will be no reimbursement by Medicaid.

0071	The Adjustment/Void Reason Code is Missing/Invalid	If you are trying to adjust or void an **approved** claim: **CMS 1500** –Locator 22 must have the correct Adjustment or Void code as given in Chap V of the DMAS manual under resubmission code **UB-92** –The correct bill type must be used to identify the claim as an Adjustment or Void as given in Chap V of the DMAS manual. Also, Locator 84 must state the reason for the Adjustment or Void **NOTE:** Denied claims only need to be resubmitted, not adjusted.
0089	This Service Center is Not Authorized to Bill Medicaid	The service center, which is billing electronically for the provider, must match the service center on the provider file. Call First Health, Provider Enrollment Unit to verify the service center on file. (804) 270-5105 or, in-state only (888) 829-5373.
0116	Invalid/Missing Prescribing Physician Number	The Prescribing physician's 9 digit Medicaid number is required for claims submission. You can access prescribing provider ID numbers by contacting the MediCall line 1-800-884-9730 and selecting option "6".
0146	The Procedure Code Billed is Not on File	The procedure code billed is not on our Medicaid database. Check your claim to make sure the intended procedure was submitted, if you feel the code is correct call the Provider Helpline to verify the code billed
0147	This date of service is prior to the procedure code's effective date.	The procedure code was not effective on the dates of service billed. Check your claim to make sure the intended procedure code was submitted, if you feel the code is correct call the Helpline to check the effective date of coverage for the procedure code billed. ***NOTE:** Effective for dates of service on or after 01/01/04 DMAS requires the use of National procedure codes.
0155	Procedure Requires Authorization	The procedure/revenue code billed requires a preauthorization and there is no PA number on the claim. You must get preauthorization from the appropriate staff (WVMI, DMAS Medical Support or Outpatient Psychiatric PA Unit) depending on the service being provided. The preauthorization number received from is required in Locator 23 of the CMS-1500 and Locator 63 of the UB-92. If a preauthorization letter is received, it must be attached to the CMS-1500 with the word "Attachment" in Locator 10D and a modifier "22". On the UB-92 it must be attached with the word "Attachment" in Locator 84.

0265	Drug Cost Not on File	Claim will deny if the pharmacy claim is approved to pay and the drug cost equals zero on our system. Call Provider Helpline to verify drug cost.
0301	Duplicate Payment Request-Same Provider, Same Dates of Service	Provider has already received payment for this date of service. Review your prior remittances to identify the payment, which has already been made. If you can not locate the previous payment call the Provider Helpline ***Note**- make sure the prior remittance's provider number matches the number of the remit with the denied claim
0302	Duplicate of History File Record, Same Provider, Same Dates of Service	Provider has already received payment for this date of service. Review your prior remittance to identify the payment, which has already been made. If you can not locate the previous payment call the Provider Helpline ***Note**- make sure the prior remittance's provider number matches the number of the remit with the denied claim
0308	Your payment request was filed past the filing time limit without acceptable documentation	Virginia Medicaid is mandated by federal regulations to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Medicaid is not authorized to make payment on claims submitted after the 12 month timely filing limit, except under the conditions listed in the Physicians Manual Chapter V pgs 2-3.
0309	Services Not Covered	Verify the client's eligibility on our Medicall system. If the client is eligible, contact the Provider Helpline to verify that the client is enolled in the program for which services were billed.
0313	Enrollee is covered by private insurance, refer to third party information of this R/A	Our system indicates that there is a primary carrier, which needs to be billed prior to Medicaid. This carrier is now listed on your remittance advice under the claims information for that particular client. Please refer to this other coverage information which should be billed as primary. ***NOTE:** If the client states there is no other coverage then they will need to contact their case worker at the Department of Social Services to have this information corrected
0318	Enrollee not eligible on DOS	Claim will deny if the client is not eligible during dates of service billed. Check enrollee eligibility status through MediCall to verify eligibility on the date of service being rendered. If the enrollee is not eligible no payment will be received from Virginia Medicaid. If upon verification you find that the client is now eligible on that date of service resubmit the claim.

0326	Non-Legend Drug	Claim was submitted with a Non-legend drug, which is an Over-the-Counter Drug. Non-legend drugs are covered **only** under the conditions specified in the Pharmacy manual Chp. IV pgs. 3-5. If those conditions are not met the claim will deny.
0364	Primary carrier payment equals or exceeds DMAS' allowed amount	The claim was submitted with COB code indicating there was a primary carrier which paid on this claim and that the primary carrier's payment to you equaled or exceeded Medicaid's allowed amount. DMAS will not reimburse you if the primary carrier payment exceeds the Medicaid allowed amount.
0367	This enrollee is covered by Medicare part B, Rebill on Title 18	Medicaid requires claims be submitted on a Title 18 for Medicare Part B deductible and coinsurance. See Medicaid Memo dated 3/18/04.
0370	Wrong Procedure Code Billed	Check your claim to verify that the correct/valid procedure code was billed, if you feel the code is correct call the Provider Helpline to verify the code billed
0382	Maint Dose/Duration Exceeded-Give Diagnosis	Maintenance prescription Medicaid requires pharmacist to enter diagnosis for claim payment.
0385	Re-bill on Title XVIII Invoice	If the claim is being submitted to Medicaid for deductible and coinsurance secondary to Medicare's payment, and the claim to **Medicare** was submitted on a CMS-1500 form, then the claim to **Medicaid** must be submitted on a Title XVIII claim form.
0387	Primary Carrier Payment Needs Explanation	The claim was submitted with a COB (coordination of benefits) code indicating that there was payment from a primary carrier . There is no payment indicated and Medicaid's system states there should be. When this denial is received clarify COB billing Chapter V of the DMAS manual.
0397	Unable to locate Original Payment request	Claim was submitted as an adjustment but the former reference number submitted could not be located. Verify that the former reference number is actually the last approved reference number. Only approved claims can be adjusted. If the former claim denied, no adjustment is necessary, resubmit as an original claim.
0403	NDC Not Covered	The NDC billed is not a covered drug on the date of service based on the date set on our Drug File. Check number to verify that the correct NDC was transmitted. If so, call the Helpline to determine if there is problem with this NDC or if another code needs to be selected.

0418	ProDUR Over Utilization/Early refill	This is a drug utilization review alert. An early refill alert results when 75% of the previous script has not been used. It is automatically denied. The pharmacy provider may override the denial by submitting another POS pharmacy claim with the appropriate outcome and intervention codes
0423	NDC Not on File, Check NDC	The NDC billed is not listed on our Drug File. Check number to verify that the correct NDC was transmitted. If so, call the Helpline to determine if there is problem with this NDC or if another code needs to be selected.
0453	Enrollee in HMO	Client is enrolled in a Medicaid HMO. Call the MediCall line to determine in which HMO the client is enrolled. Submit claims to that HMO.
0480	Provider not CLIA certified to perform procedure	Providers must put the Clinical Laboratory Improvement Amendment (CLIA) number of the physician office laboratory (POL) performing the service in Block 19 of the CMS-1500 as mandated by CMS. See details in the Physicians Manual Chp. IV page 25.
0485	Authorization by Medallion PCP not indicated	Claim was submitted without the Primary Care Physician (PCP) referral number **OR** the referral number was incorrect. Utilize the MediCall system option "1" to determine the correct PCP's telephone number. Call the PCP for the referral number. This number must be listed: CMS-1500 – Locator 17A UB-92- Locator 83A
0493	Prescribing Physician Not on File	The prescribing provider ID number submitted was not a valid Medicaid number **OR** the prescribing provider was not authorized to write prescriptions. You can verify prescribing provider ID numbers by contacting the MediCall line 1-800-884-9730 and selecting option "6".
0495	Other insurance information is missing	**CMS 1500** –claim was submitted with a COB code of '5' in Locator 24J and you must attach a statement verifying why the primary carrier did not pay. The word 'Attachment' must be in Locator 10D **UB-92** – claim was submitted with a COB code of '85' in Locator 39-41 under 'code', you must attach a statement verifying why the primary carrier did not pay. Write 'Attachment" in Locator 84. The attachment for both the CMS-1500 and UB-92 must document one of the following: • The Explanation of Benefits (EOB) from the primary carrier; or

		• A statement from the primary carrier that there is no coverage for this service; or • An explanation from the provider that the other insurance does not provide coverage for the service being billed (e.g., this is a claim for surgery and the other coverage is dental); or • A statement from the provider indicating that the primary insurance has been canceled. Claims with no attachment will be denied.
0675	ProDUR Drug/Drug Alert	This is a drug alert that informs the pharmacy provider that the drug dispensed is contraindicated for a currently active prescription that the patient has already received. Contact the patient's physician for additional information.
0729	Servicing Provider Not on File	The servicing provider is not on our Provider Enrollment Database. Verify that the correct provider number was billed, if so then you must contact First Health, Provider Enrollment Unit 804-270-5105 out of state, or 888-829-5373 in-state to verify provider's status.
0731	Servicing Provider not Eligible on DOS	Provider rendering services was not eligible on DOS. Contact First Health, Provider Enrollment Unit 804-270-5105 or 888-829-5373 to verify provider's date of eligibility.
0732	Servicing Provider Invalid	Please resubmit claim with the 9 digit provider number in Locator 33 beside PIN# **only**. ***NOTE:** if you have a seven digit provider number place two leading zeros before the number.
0756	Billing Provider is Not a Group Provider	Please resubmit claim with the 9 digit provider number in Locator 33 beside PIN# **only**. ***NOTE:** if you have a seven digit provider number place two leading zeros before the number.
0870	Unable to Match Provider Medicare Number	The Medicaid provider number was not found using the Medicare provider number given when the claim was submitted. Verify that the Medicare number on your Medicaid provider file is correct and matches exactly what is submitted. If the information submitted is correct, contact the Provider Helpline for further assistance.
0942	ProDur Therapeutic Duplication	This is a therapeutic duplication alert. It informs the pharmacy provider that this enrollee is receiving another prescription which is considered the therapeutic equivalent of the current prescription. The provider may override the denial by submitting another POS pharmacy claim with the appropriate outcome and intervention codes.

0947	Outpatient Psych Visits Limited to 26 in First Year Treatment	If the first year of treatment began prior to 07/01/03,outpatient psychiatric services are limited to 26 sessions without preauthorization, with the possibility of an additional 26 sessions when preauthorized. If initial treatment began on or after 07/01/03, outpatient psychiatric services are limited to 5 sessions in the first year of treatment with one possible extension of 47 sessions, when preauthorized, during the first year of treatment. These initial 5 sessions must be used within one year of the first date of service (anniversary date) and cannot be carried over into subsequent years. The preauthorization number must be listed on the CMS-1500 form in Locator 23. ***NOTE:** See Medicaid Memo dated 07/01/03 and Psychiatric Services Manual Chap. IV pgs. 29-30.
0961	Provider Not Approved for Electronic Billing	A payment request was submitted electronically and the billing provider is not allowed to submit electronic requests according to Provider Enrollment. Please contact First Health Provider Enrollment at (800) 924-6741 for set up of electronic billing.
0968	Non-Rebateable NDC Not Covered	The National Drug Code (NDC) must have the manufacturer code of a participating manufacturer in Medicaid's rebate program to be reimbursed. Check other NDC codes that you have on hand. **Usually** the larger name Pharmaceutical companies are rebateable.
0971	Enrollee in Plan that Provider is Not	The client being billed is enrolled in a specific program, i.e. SLH, TDO, FAMIS etc., for which the provider is not enrolled as a participant. Contact the Provider Helpline if you feel the data on our system is incorrect or you wish to be enrolled as a provider of a specific program.
0983	Enrollee Not on File	The eligibility number submitted is not on file. Recheck the ID number on our Medicall system by Social Security number and date of birth. If the individual is not a Medicaid recipient no payment will be provided for services.
0998	Days Supply Exceeds Maximum allowed	For pharmacy claims, if the days supply exceeds the maximum limit set on our system the claim will deny. Check the supply amount that was sent on the claim, if you feel this is correct contact the Helpline to verify.
1499	PDL Age Restriction 800-932-6648	If the client's age is less than the minimum age or greater than the maximum age for a particular drug or drug class, the claim will deny. Call 800-932-6648 to verify the client's age and the age on the drug file.
1520	PDL PA req.-MD call 800-932-6648	Drug submitted is not on the Preferred Drug List (PDL) and a preauthorization (PA) is required. Call 800-932-6648.